Hospital Request for Certification in the Medicare/Medicaid Program

Department of Health and Human Services
Health Care Financing Administration
Form Approved
OMB No.0938-0086

Hospitals accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) or the American Osteopathic Association (AOA) may establish their eligibility to provide services for reimbursement under the program by submitting the information on this form to the designated state agency. The signing of this form also authorizes the JCAHO or the AOA or any other national accrediting body recognized by the secretary as meeting the conditions to disclose to any authorized representative, employee, or agent of the Health Care Financing Administration a copy of the hospital's most recent accreditation survey for official use solely, except that the secretary may disclose such a survey and information related to such a survey to the extent such survey and information relate to an enforcement action taken by the secretary. It is understood that survey information disclosed to the Health Care Financing Administration shall be treated in accordance with the rule of confidentiality and disclosure contained in §401.126 and §401.133, PART 401 of subchapter a TITLE 42 of the code of federal regulations.

I. Medicare/Medicaid

Provider Number: _____

Vendor Number: _____

[ ] 0 Not Accredited [ ] 1 JCAHO Accredited [ ] 2 AOA Accredited

[ ] 3 Other [ ] 4 Both JCAHO and AOA Accredited

Effective Date of Accreditation: _____ (mm/dd/yy) (M1)

Expiration Date of Accreditation: _____ (mm/dd/yy) (M2)

State/Country Code: _____ (M3)

State Region Code: _____ (M4)

II. Identifying Information

Name and Address of Hospital (Include City/County, State, Zip Code)

_____

_____

_____

Fiscal Year Ending Date: _____ (mm/dd)

Request to established eligibility in:

[ ] 1 Medicare [ ] 2 Medicaid [ ] 3 Both (M5)

CLIA I.D. Number(s) (List the CLIA Numbers for the Hospital Laboratories) _____ (M6)

Telephone Number (Including Area Code): _____

Fax Number (including Area Code): _____

Related Provider Number: _____ (M8)

Attach a list (M30).

III. Type of Hospital (Enter one from A that most accurately describes the hospital. Check all that apply in column B).

A.(M9)
[ ] 01 Short-term
[ ] 02 Long-term
[ ] 03 Religious Non-Medical Health Care Institution
[ ] 04 Psychiatric
[ ] 05 Rehabilitation
[ ] 06 Children
[ ] 11 Critical Access Hospital

B.(M10)
[ ] 1 Regional Referral Center
[ ] 2 Mayo Clinic Exception
[ ] 3 Sole Community
[ ] 4 Cancer
[ ] 5 Psychiatric Unit
[ ] 7 Rehabilitation Unit
[ ] 8 Hospital Swing Bed
[ ] 10 Hospital Within A Hospital—Tenant
[ ] 11 Hospital Within A Hospital—Host

IV. Physician Training Program

A. Affiliated with a Medical School (M11)

[ ] 1. Major
[ ] 2. Limited
[ ] 3. Graduate
[ ] 4. No Affiliation

B. Resident Programs Approved by: (Check all that apply)
[ ] 1. AMA
[ ] 2. ADA
[ ] 3. AOA
[ ] 4. Other
[ ] 5. No Program

V. Type of Control (Enter One) (M13)

Voluntary Nonprofit
[ ] 01 Church
[ ] 02 Private
[ ] 03 Other (Specify)
[ ] 04 Proprietary (M13) _____

Government
[ ] 05 Federal
[ ] 06 State
[ ] 07 Local
[ ] 08 Hospital District or Authority

VI. Services Provided: If by staff, enter a "1" in the block(s); if under arrangement, enter a "2" in the block(s); if provided by both, enter a "3" in the block. Leave blank if the service is not provided. (M14)

[ ] 1. Acute Renal Dialysis
[ ] 2. Alcohol and/or Drug Services
[ ] 3. Anesthesia Services
[ ] 4. Blood Bank
[ ] 5. Burn Care Unit
[ ] 6. Chiropractic Services
[ ] 7. Coronary Care Unit
[ ] 8. Dental Service
[ ] 9. Dietetic Services
[ ] 10.Emergency Services (organized)
[ ] 11. Home Care Program
[ ] 12. Hospice
[ ] 13. Inpatient Surgical Services
[ ] 14. Intensive Care Unit
[ ] 15. Laboratory Service (Clinical)
[ ] 16. Laboratory Service (Anatomical)
[ ] 17. Long-Term Care Unit
[ ] 18. Neonatal Nursery
[ ] 19. Nuclear Medicine Services
[ ] 20. Obstetrics
[ ] 21. Occupational Therapy Services
[ ] 22. Open Heart Surgery Facilities
[ ] 23. Operating Room(s)
[ ] 24. Optometric Services
[ ] 25. Organ Bank
[ ] 26. Organ Transplant Services
[ ] 27. Outpatient Services
[ ] 28. Outpatient Surgery Unit
[ ] 29. Pediatric Services
[ ] 30. Pharmacy
[ ] 31. Physical Therapy Services
[ ] 32. Postoperative Recovery Rooms
[ ] 33. Psychiatric Services
[ ] 34. Radiology Services (Diagnostic)
[ ] 35. Radiology Services (Therapeutic)
[ ] 36. Rehabilitation Services
[ ] 37. Respiratory Care Services
[ ] 38. Self Care Unit
[ ] 39. Shock Trauma
[ ] 40. Social Services
[ ] 41. Speech Pathology Services

VII. Number of Employees Salaried by Hospital (Full-Time Equivalent)

Physicians (Salaried Only) _____ (M15)
Licensed Practical/Licensed Vocational Nurses _____ (M16)
Registered Pharmacists _____ (M17)
Occupational Therapists _____ (M18)
Physical Therapists _____ (M19)
Residents (Physicians) _____ (M20)
Licensed Practical/Licensed vocational Nurses _____ (M21)
Medical Social Workers _____ (M22)
Speech Therapists _____ (M23)
Physician Assistants _____ (M24)
Inhalation Therapists _____ (M25)
Dietitians _____ (M26)
Certified Registered Nurse Anesthetist (CRNA) _____ (M27)
All Others _____ (M28)

Whoever knowingly or willfully makes or causes to be made a false statement or representation on this form may be prosecuted under applicable federal or state laws. In addition, knowingly and willfully failing to fully and accurately disclose the information requested may result in denial of a request to participate, or where the entity already participates, a termination of its agreement of contract with the state agency or the secretary as appropriate.

Name of Authorized Representative

Signature _____

Typed Name: _____

Typed Title: _____

Name of Administrator

Signature _____

Typed Name: _____

Typed Title: _____

Date: _____/_____/_____ (mm/dd/yy) (M29)

Mail this form to:

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2nd floor
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